# PATIENT REGISTRATION

Green Valley DENTAL

**Monroe Phone** (608) 328-8228
**Monticello Phone** (608) 938-4001
**Email** frontdesk@greenvalleydds.com
**greenvalleydds.com**

First Name _____ Last Name _____ Middle Initial _____

Address _____

City, State, Zip _____

Home Phone _____ Cell Phone _____ Other Phone _____

**Sex** ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Date of Birth _____ Email _____

SSN _____ Driver's License # _____ State _____

**Employment Status** ☐ Full Time ☐ Part Time ☐ Retired ☐ Other

## Responsible Party *(If someone other than patient)*

**Responsible Party is also a Policy Holder for Patient** ☐ Primary Insurance Holder ☐ Secondary Insurance Holder

First Name _____ Last Name _____ Middle Initial _____

Address _____

City, State, Zip _____

Home Phone _____ Cell Phone _____ Other Phone _____

**Sex** ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Birth Date _____ SSN _____ Drivers Lic. _____ State _____

Email _____

**Employment Status** ☐ Full Time ☐ Part Time ☐ Retired ☐ Other

*(Continued on next page)*

**Does Patient have Dental Insurance** ☐ Yes ☐ No *(If yes, please fill out information below)*

**Is the patient the policy holder?** ☐ Yes ☐ No *(If yes, please fill out Responsible Party Section below)*

---

## Primary Insurance Information

Name of Insured _____

**Relationship to Insured** ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured SSN _____ Insured Birth Date _____

Employer _____ Ins. Company _____

---

## Secondary Insurance Information

Name of Insured _____

**Relationship to Insured** ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured SSN _____ Insured Birth Date _____

Employer _____ Ins. Company _____